General

Guideline Title

The care of women requesting induced abortion.

Bibliographic Source(s)

Royal College of Obstetricians and Gynaecologists (RCOG). The care of women requesting induced abortion. London (England): Royal College of Obstetricians and Gynaecologists (RCOG); 2011 Nov. 130 p. (Evidence-based Clinical Guideline; no. 7).

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Royal College of Obstetricians and Gynaecologists (RCOG). The care of women requesting induced abortion. London (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2004 Sep. 104 p. (Evidence-based Clinical Guideline; no. 7). [361 references]

Recommendations

Major Recommendations

In addition to these evidence-based recommendations, the guideline development group also identifies points of best clinical practice in the original guideline document.

Levels of evidence (Ia-IV) and grading of recommendations (A–C) are defined at the end of the "Major Recommendations" field.

Commissioning and Organising Services

Access to Services

B - Services should have arrangements which facilitate access without delay for referrals from a wide range of sources.

C - Commissioners should ensure that abortion providers do not restrict access on the grounds of age, ethnicity, religious beliefs, disability or sexual orientation.

C - Professionals who are ethically opposed to abortion have a duty of care to refer onward women requesting abortion without delay.

B - Services should facilitate access for all women, particularly those who traditionally have difficulties accessing health services.

Information Provision

C - Services should make sure that written, objective, evidence-guided information is available for women considering abortion to take away before the procedure. Information should be available in a variety of languages and formats.

C - Information for women and providers should emphasise the duty of confidentiality.

Initial Assessment

C - Women who decide to continue with the pregnancy should be referred for antenatal care without delay.

C - Services should identify issues which make women particularly vulnerable (for example, child protection needs and domestic abuse/gender-based violence) and refer/signpost them on to appropriate support services in a timely manner.

C - Elements of the assessment consultation can be provided via the telephone and/or the internet. However, women should be able to access face-to-face consultation, if preferred.

Arrangements for the Procedure

C - With respect to the method used to induce the abortion, service arrangements should be such that:

- Services should be commissioned for all women requesting induced abortion at all gestations.
- If a service cannot offer an abortion by any method after a specific gestation, timely onward referral must be ensured.
- All services should be able to offer abortion by at least one of the recommended methods for each gestation band.
- All services should be able to offer a choice of recommended methods for each gestation band.
- Services should provide surgical abortion under both local and general anaesthesia.

C - To minimise delay, service arrangements should be such that:

- Referral to an abortion provider should be made within 2 working days.
- Abortion services must offer assessment within 5 working days of referral or self-referral.
- Services should offer women the abortion procedure within 5 working days of the decision to proceed.
- The total time from seeing the abortion provider to the procedure should not exceed 10 working days.
- Women requiring abortion for urgent medical reasons should be seen as soon as possible.

C - Inpatient services, provided in an appropriate centre and clinical setting, should be available for women who are unsuitable for or who do not desire home or day case care.

Commissioners should ensure that services meet the recommendations relating to:

- B - Contraception after the abortion
- A and C - Antibiotic prophylaxis
- B - Screening for sexually transmitted infections (STIs)
- C - Information provision after the abortion
- C - Counselling after the abortion

Adverse Effects, Complications and Sequelae of Abortion: What Women Need to Know

B - Women should be informed that abortion is a safe procedure for which major complications and mortality are rare at all gestations.

Abortion Complications

B - Women should be informed of the following rare but serious complication that may occur:

- Uterine rupture has been reported in association with medical abortion at late gestations. The risk is less than 1 in 1000.

B - Women should be informed of the uncommon complications that may occur and of their possible clinical consequences. These may include:

- Severe bleeding requiring transfusion; the risk is lower for early abortions, occurring in less than 1 in 1000, rising to around 4 in 1000 at gestations beyond 20 weeks.
- Uterine perforation (surgical abortion only); the risk is in the order of 1–4 in 1000 and is lower for early abortions and those performed by experienced clinicians.
- Cervical trauma (surgical abortion only); the risk of damage to the external os is no greater than 1 in 100 and is lower for early abortions

and those performed by experienced clinicians.
- Women must be informed that, should one of these complications occur, further treatment in the form of blood transfusion, laparoscopy or laparotomy may be required.

Failed Abortion and Continuing Pregnancy

B - Women should be informed that surgical and medical methods of abortion carry a small risk of failure to end the pregnancy (less than 1 in 100), necessitating another procedure.

C - Women should be informed that there is a small risk (usually much less than 5%) of the need for further intervention, such as surgical intervention following medical abortion or re-evacuation following surgical abortion.

Post-abortion Infection

B - Women should be informed that infection of varying degrees of severity may occur after medical or surgical abortion and is usually caused by pre-existing infection. Prophylactic antibiotic use and bacterial screening for lower genital tract infection reduces this risk.

Breast Cancer

A - Women should be informed that induced abortion is not associated with an increase in breast cancer risk.

Future Reproductive Outcome

B - Women should be informed that there are no proven associations between induced abortion and subsequent ectopic pregnancy, placenta praevia or infertility.

Preterm Birth

B - Women should be informed that induced abortion is associated with a small increase in the risk of subsequent preterm birth, which increases with the number of abortions. However, there is insufficient evidence to imply causality.

Psychological Sequelae

B - Women with an unintended pregnancy should be informed that the evidence suggests that they are no more or less likely to suffer adverse psychological sequelae whether they have an abortion or continue with the pregnancy and have the baby.

B - Women with an unintended pregnancy and a past history of mental health problems should be advised that they may experience further problems whether they choose to have an abortion or to continue with the pregnancy.

Pre-abortion Management

The Abortion Decision

C - Healthcare staff caring for women requesting abortion should identify those who require more support in the decision-making process.

C - Women who are certain of their decision to have an abortion should not be subjected to compulsory counselling.

Blood Tests

C - Pre-abortion assessment should always include:

- Determination of rhesus blood status.
- Where clinically indicated, pre-abortion assessment should also include:
    - Determination of blood group with screening for red cell antibodies
    - Measurement of haemoglobin concentration
    - Testing for haemoglobinopathies

B - It is not cost-effective or necessary to routinely cross-match women undergoing induced abortion.

Ultrasound Scanning

B - Use of routine pre-abortion ultrasound scanning is unnecessary.

C - Ultrasound scanning must be available to all services as it may be required as part of the assessment.

C - Before ultrasound is undertaken, women should be asked whether they would wish to see the image or not.

Prevention of Infective Complications

A/C - Services should offer antibiotic prophylaxis effective against *Chlamydia trachomatis* and anaerobes for both surgical abortion (evidence grade: A) and medical abortion (evidence grade: C).

C - The following regimens are suitable for peri-abortion antibiotic prophylaxis:

- Azithromycin 1 g orally on the day of abortion, plus metronidazole 1 g rectally or 800 mg orally prior to or at the time of abortion
  OR
- Doxycycline 100 mg orally twice daily for 7 days, starting on the day of the abortion, plus metronidazole 1 g rectally or 800mg orally prior to or at the time of the abortion
  OR
- Metronidazole 1 g rectally or 800 mg orally prior to or at the time of abortion for women who have tested negative for *C. trachomatis* infection.

STI Screening

B - All women should be screened for *C. trachomatis* and undergo a risk assessment for other STIs (for example, human immunodeficiency virus [HIV], gonorrhoea, syphilis), and be screened for them if appropriate.

C - A system for partner notification and follow-up or referral to a sexual health service should be in place.

Contraception

C - All appropriate methods of contraception should be discussed with women at the initial assessment and a plan agreed for contraception after the abortion.

Feticide

C - Feticide should be performed before medical abortion after 21 weeks and 6 days of gestation to ensure that there is no risk of a live birth.

<u>Abortion Procedures</u>

Surgical Methods

Vacuum Aspiration

B - Vacuum aspiration is an appropriate method of surgical abortion up to 14 weeks of gestation.

A - Either electric or manual vacuum aspiration may be used as both are effective and acceptable to women and clinicians.

B - Vacuum aspiration under 7 weeks of gestation should be performed with appropriate safeguards to ensure complete abortion, including inspection of aspirated tissue.

A - Vacuum aspiration may be performed from 14 to 16 weeks of gestation; large-bore cannulae and suction tubing may be required to complete the procedure without the use of forceps to remove larger fetal parts.

C - Access to ultrasound during vacuum aspiration is recommended but not routinely required for uncomplicated procedures.

Dilatation and Evacuation

A - Surgical abortion by dilatation and evacuation (D&E), preceded by cervical preparation, is appropriate for pregnancies above 14 weeks of gestation.

B - Continuous ultrasound guidance during D&E is recommended to reduce the risk of surgical complications.

Cervical Preparation for Surgical Abortion

B - Cervical preparation should be considered in all cases.

B - The following regimens are recommended for cervical preparation up to 14 weeks of gestation:

- Misoprostol 400 micrograms administered vaginally 3 hours prior to surgery or sublingually 2–3 hours prior to surgery.

B - Vaginal misoprostol can be administered either by the woman herself or by a clinician.

B - After 14 weeks of gestation, osmotic dilators provide superior dilatation to medical methods; however, misoprostol is an acceptable alternative up to 18 weeks of gestation.

A - Use of medications containing oxytocin or ergometrine is not recommended for prophylaxis to prevent excessive bleeding at the time of vacuum aspiration.

Pain Relief for Surgical Abortion

Anaesthesia

B - Services should be able to provide surgical abortions without resort to general anaesthesia.

C - If conscious sedation is used during surgical abortion, it should be undertaken only by trained practitioners and in line with Department of Health (DH) guidance.

Analgesia

B - Women should routinely be offered pain relief such as non-steroidal anti-inflammatory drugs (NSAIDs) during surgical abortion.

A - Prophylactic paracetamol (oral or rectal) is ineffective in reducing pain after surgical abortion and is not recommended.

Medical Methods

B - Medical abortion regimens using 200 mg oral mifepristone and misoprostol are effective and appropriate at any gestation.

Medical Abortion at ≤63 Days of Gestation (Early Medical Abortion)

B - The following regimens are recommended for early medical abortion:

- At ≤63 days of gestation, mifepristone 200 mg orally followed 24–48 hours later by misoprostol 800 micrograms given by the vaginal, buccal or sublingual route
- At ≤49 days, 200 mg oral mifepristone followed 24–48 hours later by 400 micrograms of oral misoprostol.

B - For women at 50–63 days of gestation, if abortion has not occurred 4 hours after administration of misoprostol, a second dose of misoprostol 400 micrograms may be administered vaginally or orally (depending upon preference and amount of bleeding).

Medical Abortion at 9–13 Weeks of Gestation

A - The following regimen is recommended for medical abortion between 9 and 13 weeks of gestation:

- Mifepristone 200 mg orally followed 36–48 hours later by misoprostol 800 micrograms vaginally. A maximum of four further doses of misoprostol 400 micrograms may be administered at 3-hourly intervals, vaginally or orally.

Medical Abortion at 13–24 Weeks of Gestation

A - The following regimen is recommended for medical abortion between 13 and 24 weeks of gestation:

- Mifepristone 200 mg orally, followed 36–48 hours later by misoprostol 800 micrograms vaginally, then misoprostol 400 micrograms orally or vaginally, 3-hourly, to a maximum of four further doses.
- If abortion does not occur, mifepristone can be repeated 3 hours after the last dose of misoprostol and 12 hours later misoprostol may be recommenced.

B - Surgical evacuation of the uterus is not required routinely following medical abortion between 13 and 24 weeks of gestation. It should be undertaken only if there is clinical evidence that the abortion is incomplete.

Pain Relief for Medical Abortion

B - Women should routinely be offered pain relief (for example, NSAIDs) during medical abortion.

A - Oral paracetamol has not been shown to reduce pain more than placebo during medical abortion and is not recommended.

B - Some women may require additional narcotic analgesia, particularly after 13 weeks of gestation.

Histopathology

C - Routine histopathological examination of tissue obtained at abortion procedures is not recommended.

Gestational Trophoblastic Neoplasia

C - Routine screening of women for gestational trophoblastic neoplasia (GTN) at the time of abortion is not recommended; providers should be aware of the signs and symptoms and, where appropriate, facilitate referral into a GTN monitoring programme.

Care after the Abortion

Rhesus Prophylaxis

B - Anti-D IgG should be given, by injection into the deltoid muscle, to all non-sensitised RhD negative women within 72 hours following abortion, whether by surgical or medical methods.

Follow-up after Abortion

B - There is no medical need for routine follow-up after surgical abortion or after medical abortion if successful abortion has been confirmed at the time of the procedure.

C - Ultrasound examination should not be used routinely to screen women for incomplete abortion.

C - The decision to evacuate the uterus following incomplete abortion should be based on clinical signs and symptoms and not on ultrasound appearance.

Contraception After Abortion

B - Abortion services should be able to provide all methods of contraception, including long-acting methods, immediately after abortion.

B - Women should be advised of the greater effectiveness of long-acting reversible methods of contraception.

B - Before she is discharged, future contraception should have been discussed with each woman and contraceptive supplies should have been offered.

B - The chosen method of contraception should be initiated immediately.

B - Intrauterine contraceptives can be inserted immediately following medical and surgical abortion at all gestations as long as it is reasonably certain that the woman is not still pregnant.

Sterilisation

B - Sterilisation can be safely performed at the time of induced abortion, although this may be more likely to be associated with regret and failure.

Definitions:

The definitions of the types of evidence used in this guideline originate from the United States Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research).

Levels of Evidence

Ia	Evidence obtained from meta-analysis of randomised trials
Ib	Evidence obtained from at least one randomised controlled trial
IIa	Evidence obtained from at least one well-designed controlled study, without randomisation
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study

III	Evidence obtained from well-designed non-experimental descriptive studies, correlation studies, and case studies
IV	Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

Grades of Recommendation

Grade of Recommendation	Level of Evidence*
A	Requires at least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (*evidence levels Ia, Ib*)
B	Requires the availability of well-conducted clinical studies, but no randomised clinical trials on the topic of the recommendation (*evidence levels IIa, IIb, III*)
C	Requires evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities; indicates an absence of directly applicable clinical studies of good quality (*evidence level IV)*
Good Practice Points	Recommended best practice based on the clinical experience of the Guideline Development Group

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Unwanted pregnancy

Guideline Category

Evaluation

Management

Risk Assessment

Treatment

Clinical Specialty

Family Practice

Internal Medicine

Nursing

Obstetrics and Gynecology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Hospitals

Nurses

Physician Assistants

Physicians

Public Health Departments

Guideline Objective(s)

- To ensure that all women considering induced abortion have access to a service of uniformly high quality
- To assist clinicians and patients in making decisions about appropriate treatment
- To update the 2004 version of the guideline on *The Care of Women Requesting Induced Abortion*, prompted mainly by a recommendation of the House of Commons Science and Technology Committee, which in 2007 considered *Scientific Developments relating to the Abortion Act 1967*

Target Population

Women in Great Britain seeking abortion and meeting the requests of the abortion act

Interventions and Practices Considered

Evaluation/Pre-abortion Management

1. Provision of information about the abortion procedure and potential complications, as well as indications for patient counseling
2. Prompt referral and assessment appointment within 5 days of referral
3. Measurement of haemoglobin, blood group determination (ABO, Rhesus [Rh]); screening for red cell antibodies; testing for haemoglobinopathies
4. Cervical cytology history; cervical smear if not previously done at recommended interval
5. Ultrasound scanning
6. Minimizing the risk of post abortion infective morbidity (antibiotic prophylaxis or screening for lower genital tract organisms with treatment of positive cases)
7. Sexually transmitted infection screening and risk assessment
8. Discussion of contraceptive methods
9. Feticide before medical abortion after 21 weeks and 6 days of gestation

Abortion Procedures

1. Surgical abortion
    - Vacuum aspiration
    - Dilatation and evacuation
    - Cervical preparation for surgical abortion
    - Pain relief for surgical abortion (anaesthesia, analgesia)
2. Medical abortion
    - Mifepristone followed by misoprostol
    - Completion of medical abortion at home
    - Surgical evacuation after medical abortion (for incomplete abortion; not recommended routinely)
    - Pain relief for medical abortion (non-steroidal anti-inflammatory drugs [NSAIDs])
3. Routine histopathology following abortion (considered but not recommended)
4. Routine screening for gestational trophoblastic neoplasia (considered but not recommended)

Aftercare and Follow-up

1. Rhesus prophylaxis (Anti-D IgG immunoprophylaxis for non-sensitized RhD negative women)
2. Provision of post-abortion information
3. Follow-up appointment (only if necessary)
4. Referral for further counselling (if necessary)
5. Discussion and offering of contraception

Major Outcomes Considered

- Incidence of complications from the abortion (e.g., haemorrhage [>500 ml], cervical laceration, uterine perforation, retained products, infection, and maternal death)
- Failure rates/success rates of abortion procedures
- Complete abortion rate
- Reproductive sequelae
- Efficacy of medical abortion regimens
- Induction-abortion time intervals of medical abortions
- Cost
- Future reproductive outcomes

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Literature Search Strategy

The aim of the literature review was to identify and synthesise relevant evidence within the published literature, thus enabling clinical practice recommendations to be based on evidence wherever possible.

In developing the earlier versions of this guideline, searches were carried out for each topic of interest. The electronic database MEDLINE (Ovid version including foreign language publications) was searched for the period January 1966 to September 2003. The searches were performed using relevant medical subject headings (MeSH) terms and text words. In addition, the electronic database EMBASE was searched between 1974 and September 2003 to identify publications, usually European, not indexed on MEDLINE. The Cochrane Library was searched to identify systematic reviews, meta-analyses and controlled clinical trials. Reference lists of non-systematic review articles and studies obtained from the initial search were trawled and journals in the Royal College of Obstetricians and Gynaecologists (RCOG) library were hand-searched to identify articles not yet indexed. There was no systematic attempt to search the 'grey literature' (conferences, abstracts, theses and unpublished trials).

In developing this edition, similar literature searches were carried out covering the period 2003 to February 2011.

Rather than undertaking a new search, where available, systematic reviews were used, including those undertaken for the revision of the World Health Organization (WHO) guidelines for safe abortion. These reviews are listed in Appendix 2 of the original guideline document together with the tables of evidence used in the absence of appropriate published reviews. For WHO, Cochrane systematic reviews including randomised clinical trials (RCTs) were the primary source of evidence. Relevant Cochrane systematic reviews were identified and the need for updating these was determined. Relevant and possibly relevant Cochrane systematic reviews were identified and those that were considered outdated were updated using their specific, standard search strategies. Additionally, three systematic reviews were conducted outside of the Cochrane Database

of Systematic Reviews and were published in peer-reviewed journals. The search strategies and the specific criteria for including and excluding trials identified by the search are provided in the corresponding systematic review.

Sifting and Reviewing the Literature

For both the original and updated literature searches, a preliminary scrutiny of titles and abstracts was undertaken and full papers were obtained if they were relevant to the topic. Articles not relevant to the subject in question were rejected, as were articles where relevant outcomes were not reported. For all the subject areas, published systematic reviews or meta-analyses were used, if available. If these did not exist, RCTs were sought. For subject areas where a body of systematic review or randomised trial evidence was available, studies of less robust design were not systematically sought. Where there were no relevant published RCTs, other appropriate experimental or observational studies were sought.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence*

Ia	Evidence obtained from meta-analysis of randomised trials
Ib	Evidence obtained from at least one randomised controlled trial
IIa	Evidence obtained from at least one well-designed controlled study, without randomisation
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study
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*The definitions of the types of evidence used in this guideline originate from the United States Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research).

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Synthesising the Evidence

Identified articles were assessed methodologically and the best available evidence was used to form and support the recommendations. If a good systematic review, meta-analysis or randomised controlled trial (RCT) existed in relation to a topic, studies of a weaker design were ignored. The evidence was synthesised using qualitative methods. These involved summarising the content of identified papers in the form of evidence tables and agreeing brief recommendation statements that accurately reflected the relevant evidence. Quantitative techniques (meta-analyses) were not performed by the Guideline Development Group (GDG) because of time constraints and the difficulty of combining studies of various designs.

Systematic Reviews

In updating this guideline, the GDG was fortunate to have access to a large number of relevant systematic reviews. These rendered redundant some of the evidence tables included in the appendix of the previous version. For the benefit of readers who would like a quick reference guide to the sources of evidence used in the guideline, the major systematic reviews are listed according to the topic covered in Appendix 2 of the original guideline document. Where systematic reviews were either not available or not sufficient for the group's purposes, the evidence tables are displayed. For some topics for which no systematic reviews have been published, the tables published in the 2004 guideline are reproduced since no new evidence was found.

Methods Used to Formulate the Recommendations

Expert Consensus

Informal Consensus

Description of Methods Used to Formulate the Recommendations

The revision of the guideline was undertaken by a multiprofessional group which was supported by the Department of Health (DH). Members of the Group included representatives of the Royal College of Obstetricians and Gynaecologists (RCOG), the Faculty of Sexual & Reproductive Healthcare (FSRH), the Royal College of General Practitioners (RCGP) and the Royal College of Nursing (RCN) as well as commissioners and providers of abortion services within the National Health Service (NHS) and the independent sector, and a member of the RCOG Consumers' Forum.

The Group was fortunate that during 2009/10 the Human Reproduction Programme of the World Health Organization (WHO) undertook a formal exercise to update its own guidelines for safe abortion (*Safe Abortion: Technical and Policy Guidance for Health Systems*). The WHO kindly made available to the RCOG all of the updated systematic reviews of the evidence prepared for the WHO process and Dr Nathalie Kapp, Medical Officer in the WHO Department of Reproductive Health, attended a number of meetings of the Guideline Development Group (GDG).

Forming and Grading the Recommendations

Recommendations were based on, and explicitly linked to, the evidence that supports them. Recommendations were derived from available research evidence using consensus methods. Where there were areas without available research evidence, consensus was again used.

As part of the consensus process, the recommendations published in the 2004 guideline were circulated to members of the GDG. For each recommendation, members were asked to indicate whether they thought that the recommendation should be included as it stood, included with modifications or excluded, and whether any new recommendations should be developed. This approach ensured that all Group members had an equal opportunity to express their views on recommendations. The Group used an informal consensus process to agree modified recommendations.

The recommendations were then graded according to the level of evidence upon which they were based. The grading scheme used was formulated by the Clinical Outcomes Group and recommended by the National Health Service Executive.

The strength of the evidence on which each recommendation is based is shown in the "Rating Scheme for the Strength of the Recommendations" field. It is accepted that, in this grading system, the evidence itself is not graded according to quality, although it is discussed narratively in the text supporting each recommendation. It is also accepted that randomised controlled trials (RCTs) may not always be the most appropriate study design (for example, to investigate diagnostic tests). Similarly, there may be clinical questions that cannot easily be answered by experiment but nevertheless represent good practice. Such recommendations will automatically be graded C or "Good Practice Points."

The validity of some grade C and "Good Practice Point" recommendations may be questionable, as they are not based upon incontrovertible evidence. However, the views of the 2010/2011 GDG, combined with comments from extensive peer review, suggest that the recommendations with this grading are acceptable to a wide body of expert opinion.

Rating Scheme for the Strength of the Recommendations

Grades of Recommendation

Grade of Recommendation	Level of Evidence*
A	Requires at least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (*evidence levels Ia, Ib*)
B	Requires the availability of well-conducted clinical studies, but no randomised clinical trials on the topic of the recommendation (*evidence levels IIa, IIb, III*)
C	Requires evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities; indicates an absence of directly applicable clinical studies of good quality (*evidence level IV)*
Good Practice Points	Recommended best practice based on the clinical experience of the Guideline Development Group

*See the "Rating Scheme for the Strength of the Evidence" field for the evidence level definitions.

Cost Analysis

Details of the cost effectiveness of practices are discussed in the original guideline document.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Successive drafts of the original guideline were written and discussed by the Guideline Development Group (GDG) until a formal peer review process was undertaken. Members of the Group suggested names of individuals or organisations from the area of practice that they represented and the draft guideline was sent to individuals chosen by the Department of Health and the Royal College of Obstetricians and Gynaecologists (RCOG). The draft was also posted on the RCOG website and comments were invited from any member of the public. Comments received were reviewed by the development team and changes were made to the document where necessary. Equal consideration was given to comments made by the nominated peer reviewers and members of the public, and all comments were taken into account when finalising the document.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

It is anticipated that there will be health benefits for women seeking induced abortion in the form of consistent, high quality service, and prompt, effective treatment.

Additional benefits include:

- Reduced risk of complications
- Reduced costs
- Increased success rate

Potential Harms

Complications of Abortion

- Uterine rupture has been reported in association with medical abortion at late gestations. The risk is less than 1 in 1000.
- Severe bleeding requiring transfusion; the risk is lower for early abortions, occurring in less than 1 in 1000, rising to around 4 in 1000 at gestations beyond 20 weeks.
- Uterine perforation (surgical abortion only); the risk is in the order of 1–4 in 1000 and is lower for early abortions and those performed by experienced clinicians.
- Cervical trauma (surgical abortion only); the risk of damage to the external os is no greater than 1 in 100 and is lower for early abortions and those performed by experienced clinicians.
- Should one of the above complications occur, further treatment in the form of blood transfusion, laparoscopy or laparotomy may be required.
- Surgical and medical methods of abortion carry a small risk of failure to end the pregnancy (less than 1 in 100), necessitating another procedure.
- There is a small risk (usually much less than 5%) of the need for further intervention, such as surgical intervention following medical abortion or re-evacuation following surgical abortion.
- Infection of varying degrees of severity may occur after medical or surgical abortion and is usually caused by pre-existing infection. Prophylactic antibiotic use and bacterial screening for lower genital tract infection reduces this risk.
- Induced abortion is associated with a small increase in the risk of subsequent preterm birth, which increases with the number of abortions. However, there is insufficient evidence to imply causality.
- A small minority of women experience clinically significant psychological sequelae after abortion.
- Side effects of agents used for medical abortion

Qualifying Statements

Qualifying Statements

- The guideline was developed in relation to abortion legislation and available resources in England, Wales, and Scotland. The different issues surrounding induced abortion in countries with different legislation and with different levels of resources and facilities are not considered.
- Registered names: The use of registered names, trademarks, etc. in this publication does not imply, even in the absence of a specific statement, that such names are exempt from the relevant laws and regulations and therefore free for general use.
- Product liability: Drugs and their doses are mentioned in this text. While every effort has been made to ensure the accuracy of the information contained within this publication, neither the authors nor the publishers can accept liability for errors or omissions. The final responsibility for delivery of the correct dose remains with the physician prescribing and administering the drug. In every individual case the respective user must check current indications and accuracy by consulting other pharmaceutical literature and following the guidelines laid down by the manufacturers of specific products and the relevant authorities in the country in which they are practising.

Implementation of the Guideline

Description of Implementation Strategy

Local Protocol Development

It is anticipated that this national guideline will be used as the basis for the development of local protocols or guidelines which will take into account local service provision and the needs and preferences of the local population. Such local adaptation should take place in a similar multidisciplinary group in consultation with all parties affected by the guidelines. It is essential that commissioners of healthcare, as well as general practitioners,

specialists, and service users, take part in such a process.

See also the chapter "Standards for Audit and Service Accreditation" in the original guideline document.

Implementation Tools

Audit Criteria/Indicators

Patient Resources

Quick Reference Guides/Physician Guides

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Timeliness

Identifying Information and Availability

Bibliographic Source(s)

Royal College of Obstetricians and Gynaecologists (RCOG). The care of women requesting induced abortion. London (England): Royal College of Obstetricians and Gynaecologists (RCOG); 2011 Nov. 130 p. (Evidence-based Clinical Guideline; no. 7).

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2000 (revised 2011 Nov)

Guideline Developer(s)

Royal College of Obstetricians and Gynaecologists - Medical Specialty Society

Source(s) of Funding

The revision of the guideline was undertaken by a multiprofessional group which was supported by the Department of Health (DH).

Guideline Committee

Guideline Development Group

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

All members of the Guideline Development Group made formal declarations of interest, which are detailed in Appendix 1 of the original guideline document. The College was of the opinion that in each case the interests declared did not conflict with the guideline development process.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Royal College of Obstetricians and Gynaecologists (RCOG). The care of women requesting induced abortion. London (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2004 Sep. 104 p. (Evidence-based Clinical Guideline; no. 7). [361 references]

Guideline Availability

Electronic copies: Available from the Royal College of Obstetricians and Gynaecologists Web site .

Print copies: Available from the Royal College of Obstetricians and Gynaecologists (RCOG) Bookshop, 27 Sussex Place, Regent's Park, London NW1 4RG; Telephone: +44 020 7772 6276; Fax, +44 020 7772 5991; e-mail: bookshop@rcog.org.uk. A listing and order form are available from the RCOG Web site .

Availability of Companion Documents

The following is available:

- The care of women requesting induced abortion. Summary of recommendations. London: RCOG Press; 2011. 20 p. Electronic copies: Available in Portable Document Format (PDF) from the Royal College of Obstetricians and Gynaecologists Web site .

Additionally, audit criteria are summarized in Chapter 9 of the original guideline document .

Patient Resources

The following is available:

- Abortion care: Information for you. Royal College of Obstetricians and Gynaecologists (RCOG), 2012 Feb. 10 p. Electronic copies: Available from the Royal College of Obstetricians and Gynaecologists Web site .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This summary was completed by ECRI on January 8, 2001. It was verified by the guideline developer as of February 6, 2001. This NGC summary was updated by ECRI on September 9, 2005. The updated information was verified by the guideline developer on October 11, 2005. This summary was updated by ECRI on March 7, 2006 following the updated FDA advisory on Mifeprex (mifepristone). This summary was updated by ECRI on May 10, 2006 following the updated FDA advisory on Mifeprex (mifepristone). This NGC summary was updated by ECRI Institute on June 7, 2012. The information was verified by the guideline developer on June 15, 2012. This summary was updated by ECRI Institute on September 18, 2015 following the U.S. Food and Drug Administration advisory on non-aspirin nonsteroidal anti-inflammatory drugs (NSAIDs).

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